

Correspondence

Alcohol and Other Drug Dependence Among Latinos

TO THE EDITOR: I was extremely concerned regarding the Medical Staff Conference "Issues in Latino Health Care" in the February issue.¹ It completely ignored the role of alcohol and other drug dependence as significant problems for the Latino ethnic group. I will cite three references that thoroughly review the subject:

1. Gilbert M, Cervantes R: Patterns and practices of alcohol use among Mexican-Americans: A comprehensive review. *Hispanic Journal of Behavioral Sciences* 1986; Vol 8:1-60

2. Caetano R: Drinking patterns and alcohol problems among Hispanics in the U.S.: A review. *Drug Alcohol Depend* 1983; 12:37-59

3. Arredondo R, Weddige RL, Justice CL, et al: Alcoholism in Mexican-Americans: Intervention and treatment. *Hosp Community Psychiatry* 1987; 38:180-183

Alcohol and drug dependence continues to be a serious problem for the Hispanic ethnic group.

P. JOSEPH FRAWLEY, MD.
Chief of Staff
Schick Shadel Hospital
45 E Alamar St
Santa Barbara, CA 93105

REFERENCE

1. Pérez-Stable EJ: Issues in Latino health care—Medical Staff Conference, University of California, San Francisco. *West J Med* 1987 Feb; 146:213-218

Donor Notification for Positive Non-A, Non-B Hepatitis Surrogate Testing

TO THE EDITOR: Antibody to hepatitis B core antigen (anti-HBc) is present in the serum of people who have acute or chronic hepatitis B virus infection. It is frequently detectable in people who have recovered from hepatitis B. Recent reports^{1,2} suggested a correlation between the presence of anti-HBc in donated blood and the incidence of transfusion-associated non-A, non-B hepatitis (NANBH). These reports prompted the American Association of Blood Banks (AABB) in November 1986 to recommend routine alanine aminotransferase and anti-HBc as surrogate screening tests for all donors to reduce the risk of NANBH transmission through transfusions (E. M. Berkman, MD, letter to American Association of Blood Bank membership, August 15, 1986). On January 20 and 21, 1987, the Food and Drug Administration (FDA) sponsored a workshop concerning the problems of surrogate testing for preventing posttransfusion NANBH. A problem concerns informing the donor as an obligation of the collection center. Confusing the donor with information describing surrogate tests as "not good, but the best tests we have" has led many donor centers to further test donors with a profile of hepatitis B tests.³ Since physicians to whom the donor might be referred may be uncertain of the donor testing results, it was urged at the FDA workshop that the donor and physician should be provided with advisory literature. Unfortunately there is no current uniformity in retesting the donor, nor advisory information. To understand how to inform the donor, we included the following tests with our polyvalent anti-HBc

testing: IgM anti-HBc, anti-hepatitis B surface antigen (anti-HBs) and alanine aminotransferase (ALT).

Our data from the first 100 anti-HBc donors showed one donor who also had IgM anti-HBc. This same donor was hepatitis B surface antigen negative, anti-HBs negative and ALT negative, indicating by the IgM anti-HBc that this donor was possibly infectious for hepatitis B. Two thirds of these donors were positive for anti-HBs and only two had elevated ALT levels that were 2.25 standard deviations above the log mean. The IgM anti-HBc donor notification was to prevent further spread of hepatitis B; however, we do not recommend the use of this test routinely since the yield is less than 1% of anti-HBc positive donors or less than 3 per 10,000 donors. The cost of this test outweighs the benefits of informing an occasional donor.

We are currently deferring all donors who are confirmed true positive anti-HBc since this indicates past or chronic hepatitis B infection, a reason for permanent deferral. We will continue testing for anti-HBs. Those who are anti-HBc and anti-HBs positive are informed by letter, told they have been exposed to hepatitis but are immune (protected) and not to be alarmed. Those who are only anti-HBc positive are told to see a physician for further evaluation. Those who are ALT positive are not permanently deferred but, because it will be an FDA regulation, the units are discarded. We will not permanently defer these donors until we know the sensitivity, specificity and meaning of ALT testing. We feel donor notification for elevated ALT levels could lead to confusion and alarm. It could perhaps provoke enough confusion and anger in the donor for a medical malpractice suit.

DANIEL B. BRUBAKER, DO
Head of Blood Bank
SUSIE UKKESTAD, MSMT
Supervisor, Diagnostic Immunology
BYRON A. MYHRE, MD, PhD
Director of Clinical Laboratories
Department of Pathology
Harbor-UCLA Medical Center
1000 West Carson St
Torrance, CA 90509

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2. Stevens CE, Aach RD, Holliger FB, et al: Hepatitis B virus antibody in blood donors and the occurrence of non-A, non-B hepatitis in transfusion recipients. *Ann Intern Med* 1984; 101:733-738
3. FDA Workshop Examines Benefits/Problems with NANB Hepatitis Surrogate Testing. Council of Community Blood Centers Newsletter. January 23, 1987

The Achilles Heel of Computer-Initiated Bibliographic Search

TO THE EDITOR: The December 1986 special issue on Medical Informatics was timely. Among the uses of Medical Informatics, bibliographic search by computer is widespread.¹ Innovative applications allow the retrieval of more than a list of references.^{2,3} For everyone who used to labor for hours through *Index Medicus*, bibliographic searches generated by computers are a welcome convenience. I want to bring to your attention one problem encountered frequently in such searches: The lists of references are incomplete. Incomplete lists are the routine if only two command words are cross-ref-

erenced, for example "edema" and "renal failure," because the references classified under the primary heading "anuria" will be omitted. Even the more sophisticated searches⁴ provide incomplete listings more often than one would expect. Unfamiliarity of the searcher with the capabilities of the system or unusual needs of the searcher account without doubt for at least a part of the missing references. But incomplete and nonuniform coding of the articles accounts for a large share of these omissions, I suspect.

A drastic improvement of the bibliographic search will follow a uniform coding. The currently developed Unified Medical Language System⁴ will contribute to the improvement of article retrieval. I suggest that active involvement of the editorial staff of medical journals in the process of article classification and coding would be equally important. Currently, many journals do not publish "key" or "index" words. Even journals publishing "index" words provided by the authors do not provide much help because often these index words are not parts of the existing coding system and are not utilized by the coding services. I propose that journals should publish index words and that they should specify in their instructions to authors that only index words conforming to one of the existing classifications, preferably MeSH, will be published. Editorial and reviewing procedures should address this important part of the manuscripts. This process should eliminate, in most instances, the need for changes by the coding services and should give the authors an opportunity to specify their preference for classification of their work.

ANTONIOS H. TZAMALOUKAS, MD
VA Medical Center
2100 Ridgcrest Dr., SE
Albuquerque, NM 87108

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2. Collen MF, Flagle CD: Full-text medical literature retrieval by computer. *JAMA* 1985; 254:2768-2774
3. Underhill LH, Bleich HL: Bringing the medical literature to physicians. Self-service computerized bibliographic retrieval. *West J Med* 1986; 145:853-858
4. Lindberg DAB, Schoolman HM: The National Library of Medicine and Medical Informatics. *West J Med* 1986; 145:786-790

Dietary Cholesterol and Atherosclerosis

TO THE EDITOR: After 40 years and probably at least as many millions of dollars spent in the attempt, a direct cause-effect relationship between dietary cholesterol and atherosclerosis has not yet been proved; nevertheless, it has come to be accepted as common knowledge. In her otherwise exemplary, informative and well documented (46 references) article "Diet and Cancer—Should We Change What We Eat?" in the January issue,¹ Susan Desmond, MD, says the following: "coronary artery disease mortality (linked to a high-cholesterol diet). . . ." This is undocumented in the article, and a literature review is not likely to yield significant support.

The basis for this linkage is, as everyone knows, the well-documented decrease in deaths from myocardial infarction in Europe during World War II, when diets were necessarily low in cholesterol. That this concurrence was *not* in fact a cause-effect relationship has been clearly shown by review of autopsy records in Graz, Austria.² While deaths from myocardial infarction were reduced by 75% during the war, incidence of atherosclerotic coronary artery disease found at autopsy actually increased. There was a pronounced increase in mortality from infection from 1939 to 1944, with "extra

deaths from tuberculosis alone threefold greater than the drop in heart attacks."

Dr Barnes makes a good case for the association of both infectious disease and coronary artery disease with thyroid deficiency,² which he calls "the missing link in the genesis of atherosclerosis." By assiduous control of hypothyroidism, relying on basal temperature, in 1,569 cases followed over 8,824 patient-years, he found just four new cases of coronary artery disease.

Dr Barnes' work cannot be said to be controversial since it has been completely ignored, while the myth of high-cholesterol diet/coronary artery disease linkage persists. The findings of a single obscure physician need not be taken at face value, but the reported greater than 90% decrease in incidence of coronary artery disease should be sufficiently provocative to elicit further study.

RALPH S. WOLFSTEIN, MD
Associate Director
Valley Cancer Institute
14427 Chase St., #203
Panorama City, CA 91402

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2. Barnes BO: On the genesis of atherosclerosis. *J Am Geriatr Soc* 1973; 21:350-354

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Dr Desmond Responds

TO THE EDITOR: In my article on diet and cancer,¹ I attempted a thorough review of the topic based upon an extensive literature search through many more than the 46 references cited in the article. It is because of this thorough research that I felt qualified to come to conclusions regarding what general dietary guidelines may help to decrease the risk of cancer. Be assured that there has been no direct cause and effect shown between any of these dietary components and cancer. Indeed, it is rare in medicine that one can be dogmatic about proving causality. Nevertheless, as physicians and scientists, we must make causal judgments. To quote A. B. Hill, "All scientific work is incomplete—whether it be observational or experimental. All scientific work is liable to be upset or modified by advancing knowledge. That does not confer upon us a freedom to ignore the knowledge we already have or to postpone the action that it appears to demand at a certain time."²

One area of science in which a great deal of advancing knowledge has accumulated recently is that of lipids and atherosclerosis. Dr Wolfstein has questioned whether coronary artery disease can be said to be linked to a high cholesterol diet. As my personal expertise does not extend to this area, I would like to rely on the National Institutes of Health Consensus Conference to reply to this criticism.³ In December 1984 this group of lipoprotein experts, cardiologists, primary care physicians, epidemiologists, and others met to hear a series of expert presentations and to review all of the available data on lowering blood cholesterol to prevent heart disease. They concluded that "Elevated blood cholesterol is a major cause of coronary artery disease. It has been established beyond a reasonable doubt that lowering definitely elevated blood cholesterol levels will reduce the risk of heart attacks due to coronary heart disease." They also noted, "There is no doubt that appropriate changes in our diet will reduce blood cholesterol levels." These dietary changes include lowering intake of dietary total fat, saturated fat and cholesterol. Clearly, the conclusions of this Consensus Conference would